PUBLIC NOTICE OF FUNDING AVAILABILITY (NOFA)

RFA#: #04 – DMH

Intensive Home and Community Based Services

Government of the District of Columbia
Department of Mental Health

Martha B. Knisley, Director

Public Notice of Funding Availability (NOFA)

The District of Columbia, Office of the Director of the Department of Mental Health (DMH), announces the availability of DMH funds from the United States Congressional Appropriation for Foster Care Improvements in the District of Columbia from which grants will be issued.

Qualified organizations are invited to submit applications for the following Grant:

Intensive Home and Community Based Services

The target populations for the purpose of the NOFA are youth served by the District of Columbia's Child and Family Services Agency who are in foster care and meet the eligibility criteria outlined in **Section E** of this RFA.

One award will be made for a period of one year; with the expectation that the successful grantee will obtain Medicaid reimbursement for these services in subsequent years.

The Request of Applications (RFA) are now available and may be picked up at the reception desk of the following office Monday through Friday between 9am and 4pm:

Department of Mental Health
64 New York Avenue, NE
Fourth Floor
Washington, DC 20002

The deadline for submission of applications is 4:30 p.m. June 21, 2004. **Late or incomplete applications will not be forwarded for review.** Applications should be addressed to:

Evette Jackson
Project Manager
Department of Mental Health
64 New York Avenue
Washington, DC 20002
202-724-7106
ejackson@cfsa-dc.org

NOTICE

Pre-Application Conference

Applicants interested in applying for this grant, MUST ATTEND the scheduled pre-application conference.

When: June 3, 2004

Where: 64 New York Avenue, NE
5th Floor Training Room

Time: 1pm to 3pm

Contact Person: **Evette Jackson**
Department of Mental Health
64 New York Avenue, NE
Washington, DC 20002
202-671-7106

Persons and/or organizations planning to attend should RSVP via e-mail to ejackson@cfsa-dc.org not later than June 1, 2004. Not more than two representatives per agency please. Questions are encouraged and may be submitted via e-mail in advance of the pre-bidders conference to ejackson@cfsa-dc.org.

REQUEST FOR APPLICATIONS (RFA): #04
GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

INTENSIVE HOME AND COMMUNITY BASED SERVICES

A. Name of Grant: Intensive in-Home and Community Based Services (IHCBS).

B. Authority for the Grant

The Director of the District of Columbia Department of Mental Health (DMH) has the authority to make grants pursuant to the "Department of Mental Health Establishment Act of 2001, D.C. Law 14-56". Title 29 DCMR governs such grants, under Chapter 44 titled "Mental Health Grants" published in the D.C. Register as final rule on August 27, 1993.

C. Summary of Grant Notice

The Child and Family Services Agency (CFSA) and the District of Columbia Department of Mental Health (DMH) are partners in a joint effort to identify potential providers who can deliver and have an interest in delivering Intensive In-Home & Community Based Services to children, adolescents and their families who are involved with CFSA and who meet the eligibility criteria. DMH anticipates that, within the next three months, it will enter into joint cooperative agreements with a local provider/s who possess specific qualifications outlined in this RFA.

IHCBS is an intensive service designed for children and youth with serious emotional/behavioral disorders and multiple service needs who require access to an array of mental health services and supports.
IHBCS are provided in the home and community where the child lives and functions and are designed to prevent out-of-home placements, and to reunify and transition youth home from more restrictive placements. IHCBS is provided by a team of professionals that are available 24 hours a day, 7 days a week. IHCBS are family-focused and the family unit is considered the focus of treatment. Services are provided within the context of the family, culture, and community of the youth. IHCBS support a strengths-based approach, emphasizing parent and professional partnerships, linkage to natural supports, and collaboration with other agencies and child-serving systems providing services to the youth and/or family (e.g., schools, juvenile justice, child welfare, mental retardation and developmental disabilities and others). IHCBS are time-limited with the program length of stay matched to the presenting mental health needs of youth and family and the specific guidelines for the program model utilized.

DMH anticipates awarding one-year Service Enhancement/Capacity-Building grants utilizing a portion of a $3,900,000 United States Congressional Appropriation for Foster Care Improvements in the District of Columbia. The ongoing nature of these funds is not certain; therefore, CFSA and DMH have adopted a strategy to assure that the IHCBS described in this RFA and supported through these grant funds can be sustained beyond the grant period. It is envisioned and expected that grantee/s must currently be or become certified as a Core Service Agency, Sub-Provider or Specialty Provider through the DMH certification process. To sustain the IHCBS model described in this RFA beyond the grant period, the successful grantee/s shall accept Medicaid reimbursement through the DMH's Mental Health Rehabilitation Services (MHRS) option to assure the continuation of the services after year one. Therefore, certification is required within six months of the grant award, with the capability to begin billing for Medicaid for these services in the last quarter of the grant period.

The ideal provider/s selected will be capable of providing quality, culturally competent, home and community-based mental health services and supports, which are responsive to the strengths and needs of children, adolescents and families involved in the child welfare system.

D. Background and Need

Over the last two decades, there has been a sixty percent increase in the number of children entering the foster care system nationally (Barbell, 1997). The emerging research suggests that the increase is due to several factors, including the growing number of neglect cases resulting from parental drug and alcohol abuse and to the impact of poverty, homelessness, AIDS and domestic violence on at-risk families. Many of these factors, such as poverty and homelessness, are also risk factors for mental health problems in children and families, and, of course, abuse and neglect place children at very high risk for emotional disorders. Results of studies profiling the mental health status of children involved in child welfare indicate that children in foster care are three to ten times more likely to have a mental health problem than children on AFDC. For example, they are more likely to suffer from depression, anxiety disorder, ADHD, conduct disorder, bipolar disorder, and oppositional defiant disorder (Harman, J. et.al. 2000). Often, the trauma of separation and multiple placements and transitions once children are involved in child welfare aggravate mental health problems in children and families.

An effective response to the mental health needs of children and families involved in child welfare requires a strategy that will bring, on-line quickly, qualified provider/s capable of providing a range of evidence-based and promising services and supports needed by children, adolescents and families in the child welfare system that promote safety, stability, permanency and well being. To achieve this objective, CFSA and DMH are collaborating to support and identify local provider/s with the capabilities and skills to respond to the unique needs of children and families in the child welfare system.

The IHCSB provider/s selected must adhere to the standards established for this service, have the clinical staff trained in the Intensive In-Home & Community-Based Service approach by a trainer designated by DMH and enter into an ongoing consultative relationship with this trainer, and incorporate quality monitoring indicators. In other words, there are certain training and infrastructure costs associated with implementation of IHCBS over and beyond the direct service costs. DMH and CFSA intend to fund these infrastructure costs in the first year of developing a local, DC based, IHCBS provider. The local provider/s selected for this grant funding must agree to continue providing IHCBS services beyond the initial development year, and DMH expects that the service costs will be largely covered by Medicaid. Thus, it is essential that the selected provider/s become certified Mental Health Rehabilitation Services providers through the DMH process within 6 months of the grant award with the capability to begin billing Medicaid for these services in the last quarter of the grant period.

E. Scope of Work

Eligible CFSA Populations to Be Served

IHCBS shall be provided to: CFSA youth living with their custodial (natural, adoptive, foster, kin) families or with families who have made a long term commitment to the youth for the purpose of preventing out-of-home placement or disruption of the youth's living situation; or youth residing in an out-of-home placement, but transitioning back to their families or another permanent home (natural, adoptive, foster, kin) within thirty days. IHCBS are provided to youth with serious mental or emotional disorders and members of their families when the youth:

1) Meets Severely Emotionally Disturbed (SED) criteria established by the District of Columbia Department of Mental Health; AND

2) Meets one of the following criteria (as documented in the client record):
- Is at risk for out-of-home placement; or
- Has returned or is just returning from an out-of-home placement; or
- Is at risk to his/her own safety and/or the safety of others[1]; or
- Has had one or more placement disruptions in the past 12 months.

A youth consumer is defined as a youth under the age of 21 and his or her family. IHCBS services may be delivered to transitional age youth (18-21) who are still living at home with their families and are still involved in other child serving systems including schools, juvenile courts, and MRDD.

[1] Does not include youth who are actively homicidal or suicidal, but rather a youth's behaviors that create safety issues.

Capacity:

The successful grantee/s must have the capacity to operate at least one IHCBS team. An IHCBS team consists of 1 clinical supervisor who is a qualified practitioner as defined in the MHRS standards and 3-5 masters' level or highly competent bachelor's level clinicians who meet DMH/CFSA credentialing requirements. Each team member will maintain a caseload 8 but not more that 10 families with average length of stay of four to six months in the program.

Referral process:

All IHCBS referrals will originate with/from DMH ACCESS staff that will receive their referrals from the CFSA Office of Clinical Practice (OCP) Behavioral Services Unit (BSU) who will coordinate and jointly screen all referrals that meet criteria with the IHCBS Supervisor. Referrals shall be accepted by the successful grantee/s, as capacity permits.

Staff training and education requirements and organizational structure:

Initial and ongoing training and consultation from highly skilled IHCBS trainers are critical to maintaining the compliance with the IHCBS standards. DMH/CFSA plan to underwrite the cost of this training and consultation in the first year. The successful grantee/s IHCBS program staff will be trained by a highly trained IHCBS trainer designated by DMH. The cost of this training during year one will be covered by DMH with appropriation funds. This training will include both pre-service and ongoing in-service training and consultation. The level and intensity of the supervision, consultation and training will be pre-negotiated with the external consultative IHCBS team.

The overall training and development standards for IHCBS will include:

- Assessment of initial training needs of all new IHCBS personnel within 30 days of hire.
- Individualized training plans for each IHCBS personnel.
- Core IHCBS training on the following core areas, completed within six months of hire:
  1) Family Systems
  2) Risk Assessment and Crisis Stabilization
  3) Parent skills and supports for SED children
  4) Cultural competency (Special populations)
  5) Intersystem collaboration: Knowledge of other systems; system advocacy; roles and responsibilities of other child serving entities
  6) IHCBS service philosophy (principles of care)
  7) Differential diagnosis with special needs youth

- Ongoing semi-annual trainings specific to identified training needs of IHCBS providers and team.
- Each IHCBS supervisor will receive training specific to IHCBS and the supervision of IHCBS programs.

The successful grantee/s must have a demonstrated commitment to and experience with incorporating training and quality monitoring into its program operations.

IHCBS Staff Qualifications:

1. The IHCBS supervisor shall meet MHRS requirements as a qualified practitioner (as defined under the CBI or Community Support DC MHRS standard) and should be experienced in providing individual, group, marital or family counseling or psychotherapy. They will have at least three years post-degree experience working with the behaviorally challenged youth and their families in community-based settings.

2. IHCBS clinicians shall at a minimum meet the MHRS requirements as qualified and/or credentialed staff utilizing CBI and Community Support for guidance. All IHCBS supervisors and clinicians shall be assigned to the IHCBS program on a full-time basis.

3. To the extent possible, the IHCBS supervisor and team members shall reflect the racial, cultural and ethnic diversity of the children involved in CFSA.

The successful grantee/s must have demonstrated experience in employing clinical supervisory and direct care staff who work in community-based settings.

Case staffing and supervisory ratio:

1. Deliver IHCBS services to at least 12 to 15 families each year for each full-time team member.

2. Maintain a supervisory/direct service staff ratio of no more than one, full-time clinical supervisor to 3-5 IHCBS team members where each team consists of three full-time team members.

3. Assign a preferred caseload of 4 to 6 but not more than 8 families to each IHCBS team member. Services are time-limited, with the program length of stay matched to the presenting mental health needs of youth and family. IHCBS programs average 4 months length of stay. Programs must have clearly written guidelines for granting extensions and procedures for utilization review of each individual provider**.** Services are delivered in the home, school, court and community. The final two to three weeks may involve less intensive contact to monitor the maintenance of therapeutic gains.

4. Have IHCBS team members who are accessible and available to each family they serve and are able to respond to family crisis at all times, including face-to-face response as needed.

5. Regularly scheduled weekly team meetings involving all IHCBS staff, including the IHCBS supervisor, for the purpose of reviewing individual case progress, and consulting on caseworker/client manager plans, action steps and activities needed on IHCBS cases. Emphasis shall be on the IHCBS clinical supervision of all active cases and on developing outcome-focused weekly plans to achieve client/family goals.

6. Consult at a minimum of once monthly with the assigned department worker for the purpose of case reviews, program compliance, training and other department issues.

The IHCBS requires a service planning process that has the ability to:

1. Meet MHRS requirements for the Individualized Plan of Care (IPC) and the Individual Service Specific Plan (ISSP).
2. Identify the multiple determinants of anti-social behavior and emotional disturbances for each case.
3. Identify and document the strengths and needs of the adolescent, family, and the extra-familial systems (example, peers, school, neighborhood, etc.) and shall develop assessments within the social, racial and ethnic context of the youth and family.
4. In collaboration with family members, identify and document problems throughout the family and extra-familial systems (example, peers, school, neighborhood, etc.) that are explicitly targeted for change.
5. Require IHCBS therapists to write a service plan with each family. This plan will incorporate the desired outcomes of the key participants/stakeholders involved in the family's treatment (e.g. parents, probation, social services, school personnel, etc.). This plan shall be sent to the referring agency caseworker/client manager within five days from the time of referral to IHCBS. The treatment plan will identify family/client strengths, help the client/family define specific goals, provide instruction in ways to prevent the recurrence of behaviorally challenged behavior and other family conflict, and set up resources and skills to maintain ongoing progress.
6. Have the IHCBS supervisor review and approve all service plans.

The successful grantee/s must have demonstrated experience in implementing individualized, strengths-based, culturally competent service planning processes for adolescents and their families.

IHCBS Service Types:

The types of services and interventions incorporated in the IHCBS model include:

The IHCBS include assessment, care management, therapy, education, and training for families, and services to improve a family's coping skills, as well as linkage to natural helpers and supports in the community

The successful grantee/s must have demonstrated experience providing the types of services and interventions incorporated in the IHCBS model and success in working in a coordinated fashion with CFSA and/or DMH. In addition, successful grantee/s must have relationships established with non traditional community resources such as some or all of the Neighborhood Collaboratives.

Quality assurance:

1. Yearly evaluations of workers to assess knowledge of and compliance with, IHCBS philosophy and intervention strategies.

2. Participation in quality assurance evaluation activities as designated by the agencies. Activities include, but are not limited to group meetings, site visitations, audiotaped reviews of direct sessions, and peer review of policies and procedures.

The successful grantee/s will show a commitment to and demonstrate experience in incorporating quality improvement processes into their program operations.

G. Records maintenance and reporting:

The Successful grantee shall:

1. Maintain a case record for each case accepted consistent with MHRS standards. This record shall include, but is not limited to, the following:

a) Family referral sheet.
b) Date of initial request for service.
c) Results of the strength and needs assessment.
d) Service plan.
e) Goal attainment summary.
f) Family's response.
g) Ongoing progress reports, at least monthly, detailing:

- Specific interventions used and outcomes.
- Notation of every contact (IHCBS treatment logs) to include date, time and duration of contact.
- Placement status determination, including date.
- Termination summary.

h) Other material as may be specified by the referring agency/department.

2. Meet MHRS requirements for IPC and ISSP.
3. Adhere to DMH reporting requirements and be HIPAA compliant.
4. Collect, maintain and report to the agency, on a quarterly basis, information documenting progress towards achieving the outcome objectives cited in **F. Outcome Objectives below**.
5. Allow DMH and CFSA representatives' full access to all case files and administrative records for the purpose of monitoring the grant.

The successful grantee/s will have demonstrated experience in developing and maintaining record keeping and reporting systems that support integrated, coordinated provision of care and productive exchange of information with referral agencies.

F. Outcome Objectives:

1. Within the first month, the successful grantee will enter into a consultative agreement with the IHCBS trainer designated by DMH/CFSA for technical assistance in IHCBS program start-up.
2. Within the second month, the grantee will hire all necessary supervisory and direct care staff to support one IHCBS team.
3. Within the third month, all IHCBS staff will be trained by the IHCBS trainer designated by DMH/CFSA.
4. Within the third month, the grantee will have all record-keeping and reporting systems in place and relationships established with the referring CSA, CFSA and DMH.
5. Within the third month, the grantee will have a contract in place with the trainer designated by CFSA/DMH for the provision of ongoing training and consultation to IHCBS staff and supervisors.
6. By the fourth month, the grantee will begin to accept referrals from CFSA/DMH of youth eligible for IHCBS.
7. The successful grantee shall provide IHCBS services to a total of 12 to 15 youth and their families per team member during the first eighteen months of the grant period.
8. A pre-negotiated percentage of all youth and families who are accepted into the successful grantee's IHCBS Program will successfully complete the program.
9. A pre-negotiated percentage of the youth released from the successful grantee's IHCBS Program shall not be placed out-of-home within a year of program completion.
10. Evidence of positive educational/vocational involvement will be pre-negotiated with the successful grantee.

For the purpose of increasing the quality of the service, providers will be required to monitor both fidelity to the IHCBS Program Standards and submit the information to DMH and/or CFSA or their designee. Monitoring of IHCBS services will be, in part, based on the outcomes over time of that program. Programs will be asked to collect outcomes at regular intervals (intake, every 6 months while open, discharge, and 6 months following discharge).

The following are the proposed outcomes that will be required for tracking:

- Percentage of placements/permanency;
- School functioning;
- No new reports of abuse an neglect;
- Improved emotional & behavioral functioning; and
- Family satisfaction.

The IHCBS proposed standards are summarized below:

1. Intensity of Service
Minimum standard: The minimum allowable intensity for IHCBS is 2 contacts per week of face-to-face contact, with 3 hours of total service per week per family. Face-to-face contacts are defined as IHCBS provided in the home, school, and community, working directly with the consumer and family, or on behalf of the youth that benefits them as specified on the treatment plan. Total service time may include indirect service as long as the criteria of two weekly face-to-face contacts are met.

2. Location of Service
Minimum standard: The minimum standard for location of service is 75% of direct service time is delivered in the home, school, court and community.

3. Caseload:
Minimum standard: The maximum caseload, shall average 4 to 6, over any six-month period sampled, with caseload not to exceed 8 at any point in time. at any point in time. The additional caseload allowance allows flexibility for providers to take new cases while transitioning families who are ready for discharge. Caseload is defined as the individual cases open or assigned to each FTE IHCBS staff.

4. Crisis Availability
Minimum Standard: IHCBS programs have crisis availability and ability to respond by phone and/or face-to-face if necessary, 24 hours a day/7 days a week. Contract crisis services may be utilized as long as the IHCBS provider/s is reachable to the contract agency and is availability to the family as needed.

5. Safety Planning
Minimum Standard: Include safety planning and safety monitoring. Each family receiving IHBCS services shall be assessed for risk and safety issues and shall have a jointly completed safety plan that is available to the family and is instructive of steps to take in the event of a crisis. The minimum acceptable standard is evidence of safety plans and safety monitoring in a minimum of 90% of cases surveyed.

6. Family Involvement.
Minimum standard: Be strength-based and family-driven, with the youth and family regarded as equal partners in all aspects of service delivery, as evidenced in a minimum of 90% of cases surveyed in the plan of care.

7. Supervisory Support
Minimum standard:
1. Have a minimum of 2 hours of clinical supervision per week by master's level professional with two years experience with SED youth.
2. Supervisory support is available to the IHCBS provider and team 24 hours a day/7 days a week. Supervisor has a designated responsibility to the IHCBS team.

8. Professional Training and Development
Minimum standard:

- Assessment of initial training needs of all new IHCBS personnel within 30 days of hire.
- Individualized training plans for each IHCBS personnel.
- Core IHCBS training on the following core areas, completed within six months of hire:
  1) Family Systems
  2) Risk Assessment and Crisis Stabilization
  3) Parent skills and supports for SED children
  4) Cultural competency)
  5) Intersystem collaboration: Knowledge of other systems; system advocacy; roles and responsibilities of other child serving entities
  6) IHCBS service philosophy (principles of care)
  7) Differential diagnosis with special needs youth.

- Ongoing semi-annual trainings specific to identified training needs of IHCBS providers and team.
- Each IHCBS supervisor will receive training specific to IHCBS and the supervision of IHCBS programs.

9. Collaboration and Coordination of Services:
Minimum standard: Demonstrate collaboration and coordination of services in a minimum of 75% of cases surveyed based on documentation of collaborative contracts with the referral source and/or other child-serving entities as identified in the treatment plan (school, courts, etc.) For the purpose of this standard, attempts to collaborate with the appropriate documentation

10. Cultural Competency: Provider demonstrates service provision that is culturally, ethnically, racially, and linguistically appropriate and that respects and builds on the strengths of the child/family's race/culture/ethnicity, as measured by family and youth satisfaction.

10. Accessibility: Be flexible and individually tailored to meet the needs of the youth and family. IHCBS programs have written policies encouraging flexible scheduling and delivery of service. Appointments are made at a time that is convenient to the family, including evenings and weekends if necessary.

G. Typical Cost – Funding

It is anticipated that the cost[2] of this program will reflect the national averages for Intensive In-Home & Community Support Services as described in this RFA..

H. Term of Grant Services

The period for this grant will be one year from the grant award date.

I. Payments to Grantee

At the time of the award, a payment equal to twenty-five (25%) of the approved grant award will be made to the successful grantee/s to cover the cost of start-up activities related to these services. Subsequent payment will be made on a quarterly basis tied to the completion of specific milestones that will be pre-negotiated with the successful grantee/s.

J. The Grantee/s Organization – Qualification Requirements

Organizations planning to respond to this RFA **must attend** an informational meeting scheduled for **June 3rd, at 1pm at 64 New York Avenue, NE in the 5th Floor Training Room,** as a pre-condition before submitting an RFA package.

Comprehensiveness:

1. Description of the organizations overall approach to providing this service. **(Limit 4 pages)**

2. Demonstrated familiarity with the principles and practices embodied in a strength-based system of care approach for emotionally and behaviorally challenged children and their families. **(Limit to 1 page)**

3. Demonstrates a commitment to concentrate services and supports geographical area of the District of Columbia and surrounding counties where the highest percentage of children, adolescents and families involved in or at risk for involvement in child welfare reside. **(Limit 1 page)**

This costs include, staffing, overhead, initial and ongoing supervision, consultation and training for IHCBS.

4. Demonstrates a commitment and willingness to recruit qualified personnel that reflects the ethnic, racial and cultural backgrounds of the youth and family served. **(Limit 1 page)**

Experience:

1. Demonstrated commitment to and experience with incorporating training and quality monitoring into its program operations. Must have expertise with quality monitoring systems to track data and case activity in a format that is utilized by clinical staff and supervisors to improve service delivery. **(Limit 2 pages)**

2. Demonstrated experience in employing clinical supervisory and direct care staff who works in community based settings. Must have an effective clinical infrastructure that provides close supervision of staff and oversight of services provided to children and their families. **(Limit 2 pages)**

3. Demonstrated experience in implementing individualized, strengths-based, culturally competent service planning processes for children, adolescents and their families. **(Limit 2 pages)**

4. Demonstrated experience providing the types of services and interventions incorporated in the IHCBS model and success in working in a coordinated fashion with funding, governmental and/or regulatory agencies. **(Limit 1 page)**

5. Demonstrate a commitment to and demonstrated experience in incorporating quality improvement processes into their program operations. **(Limit 2 pages)**

6. Demonstrate experience in developing and maintaining record keeping and reporting systems that support integrated, coordinated provision of care and productive exchange of information with referral agencies. **(Limit 2 pages)**

7. Demonstrate knowledge of and work experience with the target population and their families identified in this RFA. (**Limit to 1 page.)**

8. Demonstrate effectiveness of treatment interventions supported by performance outcomes for the population targeted for the services identified in this NOFA. **(Limit 1 page)**

Resources:

1. Demonstrates the ability to attract and secure grant, foundation or in-kind matching funds[3] equivalent to 10% of the total grant award. **(Limit 1 page)**

2. Demonstrate linkages to and collaboration with non-traditional community and/or neighborhood-based resources such as y relationships with Neighborhood Collaboratives. **(Limit 1 page)**

3. Demonstrates current DMH certification as a MHRS provider or the ability to become certified by the District of Columbia Department of Mental Health as a MHRS provider within six months from the date of the grant agreement. **(Limit 1 page)**

4. Completion of the Budget form and narrative. **(Attachment C)**

Timeliness:
1. Demonstrate ability to start-up and implement this service within four months after grant is awarded. **(Limit 1 page)**

J. Format and Content of Qualifications

All submissions and materials must be typewritten, font size 12, and each page numbered. Submit the materials in response to this RFA on single-sided, single-spaced. Submit one original and four copies of the required materials. Organizations interested in responding to this RFA must submit the following information, for original and all copies, in the order specified below:

1. Submit a cover letter on agency letterhead. **(Limit 2 pages)**
2. Completion of the CFSA-DMH-NOFA cover sheet. **(Attachment A)**
3. A brief summary of the organization qualifications to provide the services described in this RFA. **(Limit 1 page).**
4. Responds to each of the questions listed in the Comprehensiveness, Experience, Resources and Timeliness categories of "Grantee Organization Qualifications" in Section I above.
5. In addition to responding to the items in Section I above, providers must submit the following with their qualifications:
    - A copy of the articles of incorporation with the District of Columbia or other jurisdiction or other independent proof of the start date of your organization. For non-profit organizations, copies of the IRS letters indicating their tax-exempt status (501(C) 3 letters) will suffice.
    - A list of organizations (not more than 3) for which the contractor has provided similar or identical services for the past three years, including a current contact name address, a phone number of each organization. Please provide a statement

[3] Federal funds shall be used for the 10% match requirement.

from the organization that addresses your performance for those contract/s listed on the required form. (Attachment B)

- A current balance sheet for the organization (current within the last 3 months) which clearly indicates the organization's cash flow and assets.
- A copy of the last independent audit performed for the organization, including any findings or recommendations made by the auditors and a report from the provider indicating any follow-up to those findings or recommendations to date.
- The resumes and professional qualifications of three professional staff responsible for start-up and implementation of this project and critical to the organizations performance for the scope of work detailed in this RFA. (**Resumes must be limited to 2 pages each)**.
- A statement attesting to compliance with each of the following:
  1. Wage, hour, workplace safety and other standards of labor law;
  2. Adequacy of liability insurance or ability to obtain required insurance if selected for an award;
  3. Disclosure of information about pending lawsuits or investigations, and judgments, indictments, or convictions against your organization, its partners, directors, officers, managers or staff; and
  4. Federal and District equal employment opportunity law.
  5. Agreement to contract with an IHCBS trainer selected by DMH.

K. Evaluation and Selection Criteria/Scoring Points

Comprehensiveness **20**

1. To what extent does the respondent/s present qualifications indicating their abilities to provide a comprehensive, integrated holistic approach to fulfilling the scope of work? The respondent provides evidence that they understand the work to be done, is familiar with the literature on IHCBS and is capable and eager to assist DMH and CFSA in improving mental services to children and families in foster care. Soundness of respondents' approach to work as described in this RFA.

Experience (10 points per questions) **50**

1. To what extent does the provider demonstrate experience (past and current) settings other than treatment facilities or provider offices?
2. To what extent does the provider demonstrate the incorporation of the principles and practices of a culturally competent system of care approach in their existing service delivery?
3. To what extent does the provider demonstrate experience in quality monitoring systems for tracking performance and improving services; this includes an effective clinical infrastructure in place?
4. To what extent does the provider have the ability to track and document outcomes based upon performance?
5. To what extent does the provider demonstrate an ability to engage families in the treatment process that resides in urban settings?

Resources (10 points for each question) **40**

1. Budget is reasonable and is consistent with the operational costs typical of IHCBS services.
2. To what extent does the respondent demonstrate organizational capacity and financial stability to start-up and implement grant-based services?
3. To what extent does the respondent demonstrate an on-going commitment to sustain these services utilizing Medicaid funding available through DMH as a certified MHRS certified provider?
4. To what extent does the respondent have linkages with non-traditional community and/or neighborhood-based resources, such as the Neighborhood Collaboratives?

Timeliness **10**

1. To what extent has the provider provided a timetable or schedule of how they will start-up and implementation activities related to actual service delivery?

L. Selection Process

RFAs will be scored according to the evaluation criteria listed above. The results of the evaluation for each RFA submitted will be classified into one of four categories below:

Ranking Classification	Point Range
Most Qualified	120 – 100 points
Very Qualified	99 - 80
Qualified	79 - 65
Minimally Qualified	64 and below

When the proposals are received, a panel of DMH and CFSA staff will review the proposals and rank the respondents based upon the information submitted using the criteria in this RFA. The grantee/s will be selected from among the provider/s that scores in the "Most Qualified" point range category[4]. The DMH and CFSA panel or the DMH Director may then interview providers ranking in the "most qualified" category in order to gain additional information and to determine how each respondent handles questions relevant to the performance of the services detailed in this RFA to select the grantee/s. DMH reserves the right to request additional information and verification of any statements contained in the respondent's application. The DMH may recommend that all responses to the NOFA be rejected.

[4] DMH may elect to select a grantee from the "Very Qualified " category if none of the applicants score in the "Most Qualified" range.

The selection process will be completed within 20[5] days or less, and result in a recommendation to the DMH Director for an award or a recommendation that no awards be made. When the Director makes an award, DMH and the grantee/s will enter into a written Grant Agreement. The Grant Agreement will provide for disbursement of grant funds in accordance with a schedule. The Grant Agreement will be subject to the Mental Health Grant Regulations. The Director may choose NOT to make an award.

Within 15 days after a written Grant Agreement is signed, the grantee shall begin the start-up activities in support of providing the services detailed in this grant award.

NOTE: DMH will utilize the providers ranking in the "Most Qualified" category, who are not selected through this NOFA process, for the development of future IHCBS programs for other behaviorally challenged populations meeting the program eligibility criteria served by other District agencies.

L. Audits and Disallowances

Appropriate District or Federal personnel may conduct fiscal and program audits of grantee/s either directly or by an independent auditor. The grantee/s may request an informal dispute resolution of any disallowance determination in accordance with the Mental Health Grant Guidelines. The grantee/s shall cooperate fully and promptly with any audit.

[5] This timeframe may be extended if interviews are required.

Attachment A
Cover Page

Service Title: **Intensive In-Home and Community Based Services (IHCBS)**

Administering Agency/Organization: _____

Organization/Agency Name: _____

Address: _____

_____

_____

Agency Director/Phone Number: _____/( )_____

FAX (_____)_____ **e-mail**_____

Program Contact/Phone Number: _____/( )_____

FAX (_____)_____ **e-mail**_____

Fiscal Contact/Phone Number: _____/( )_____

FAX (_____)_____ **e-mail**_____

Administering agency federal Tax Identification number: _____

Attachment B

Provider Past and/or Current Performance Form

1. **Name of Organization:** _____

2. **Address:** _____
_____
_____

3. **Phone/Fax/E-Mail** (_____)_____(____)_____**e-mail**_____

4. **Person Completing Document:** _____

5. **Relationship to Vendor/Organization i.e. contract monitor:** _____
_____

6. **Briefly describe the services provided to your organization by this organization:**
_____
_____
_____
_____
_____
_____
_____

7. **During what period of time were these services provided?**
_____
_____

8. **Please describe the population served?**
_____
_____

9. **How many youth and/or families did this vendor serve?**
_____
_____

10. **How would you rate the overall performance by this vendor for the services provided?**
Excellent_____ **Very Good**_____ **Average** _____ **Poor**_____

11. **How would you rate the quality of services provided?**
Excellent_____ **Very Good**_____ **Average** _____ **Poor**_____

12. **Print Name:**_____ **Signature/Date:** _____

Attachment C
Proposed Budget for IHCBS Services

Line Item	Grant Funds Requested	In-Kind Contributions (10% of requested grant)	Other Funds available for this project (specify source)
Salaries and Benefits:			
Staff Training			
Transportation			
Office Supplies and Equipment			
Office Space			
Telephones and pagers			
Indirect/Administrative Costs (Maximum allowed is 15% of the grant amount)			
Other Expenses: Specify in Budget Justification			
Sub-Total Grant amount Requested			
Less 10% Match Requirement			
TOTAL GRANT Amount Requested			

Budget Justification/Narrative: